

# Evidence of Vaccination against Bacterial Meningitis

**Purpose of Form:** This form may be used by any incoming student to Texas A&M University-San Antonio (TAMU-SA) in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. TAMU-SA has chosen the services of Med+Proctor to provide web-based submission. Once the documentation has been verified and approved by Med+Proctor, the university will lift the registration hold.

**This section should be completed by the student**

Student Last Name: \_\_\_\_\_ Student First Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Telephone Number: \_\_\_\_\_ Student Email Address: \_\_\_\_\_

First Semester at Texas A&M University (Select one and indicate the appropriate year):

Spring, Year: \_\_\_\_\_  Summer, Year: \_\_\_\_\_  Fall, Year: \_\_\_\_\_

By signing this form, I certify that the information provided is true and accurate and I understand the rules and regulations concerning the bacterial meningitis vaccination requirement.

Student Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**This section should be completed by a licensed Health Practitioner or Designee.**

Last/Family Name of the Health Practitioner who administered the vaccination: \_\_\_\_\_

First/Given Name of the Health Practitioner who administered the vaccination: \_\_\_\_\_

Date of the administration of the bacterial meningitis vaccination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Last/Family Name of the vaccination recipient (i.e. the student): \_\_\_\_\_

First/Given Name of the vaccination recipient (i.e. the student): \_\_\_\_\_

Date of birth of the vaccination recipient (i.e. the student): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

By signing this form, I certify that the information provided is true and accurate. Specifically, I certify the following:

I am a Health Practitioner authorized by law to administer an immunization or I have legal designation to complete and sign this form on behalf of a Health Practitioner authorized by law to administer an immunization.

The individual who administered the bacterial meningitis vaccination to the student named above is or was a Health Practitioner authorized by law to administer an immunization.

The bacterial meningitis vaccination was administered to the student named above by the Health Practitioner named above and on the date provided above.

Health Practitioner or Designee Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

License Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Use Only Received	Hold Removed
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